APPEAL NO. 93206

On December 11, 1992, a contested case hearing was held, after remand from the Appeals Panel, in (city), Texas, with (hearing officer) presiding. The hearing officer determined that the claimant, had attained maximum medical improvement (MMI) on March 30, 1992, from her work-related back injury that occurred on (date of injury), while she was employed by (employer). The hearing officer adopted the opinion of the commission-appointed designated doctor, (Dr. P), as presumptive on that issue, and found that his assessment, as to both MMI and his impairment rating, was not against the great weight of other medical evidence. The previous Appeals Panel decision was Appeal No. 92495, decided October 28, 1992.

The claimant, Ms. W, asks for reconsideration for various reasons: 1) the hearing officer abused his discretion by not granting her a continuance to allow her to review additional medical records put into evidence as a hearing officer's exhibit; 2) the hearing officer abused his discretion by not allowing her to be assisted by the ombudsman; 3) that the hearing officer directed all the questions, and acted as both judge and jury; 4) that a letter from Dr. P asserting conformity with the AMA Guides to Permanent Impairment (Guides) should not have been admitted because it was not exchanged; 5) the decision is unfair because claimant has disability and cannot work; 6) that the evidence proves that the designated doctor was biased against her, and in favor of the insurance company; and 7) that she did not have current medical evidence because the carrier has refused to pay for her medical treatment. Claimant argues that she continues to experience pain. The carrier responds that the evidence supported the hearing officer's decision, that the presumptive weight that the law requires the designated doctor's report to be given has not been overcome by the great weight of other medical evidence, and that whether or not the claimant can obtain or retain employment due to her injury does not matter for payment of benefits once maximum medical improvement is reached.

DECISION

After reviewing the record, we affirm the determination of the hearing officer.

Preliminary Matters

The hearing officer, in the interest of building a full and complete record, and in accordance with the Appeals Panel decision issued in Texas Workers' Compensation Commission Appeal No. 92495, decided October 28, 1992, ordered the carrier to produce certain additional medical evidence to the Texas Workers' Compensation Commission (Commission) and to the claimant, and then included it in the record as a hearing officer's exhibit. The hearing was held on a Friday. The claimant testified that she received these additional medical records on Monday of that week (or Tuesday at the latest) but had not had the time to review any of them. The carrier noted that these medical records had all been produced in earlier proceedings to the claimant, although neither side had introduced all of them at the previous hearing. The claimant moved for a continuance and asked for

45 days to review the records with the ombudsman. The hearing officer denied the continuance, but stated that he would hold the record open for ten days after the hearing to allow the claimant to file a written response to any records or point out where she felt they were wrong or incomplete. A review of the records indicates that they consist of medical records already in the record after the first hearing, and, for the most part, additional records from claimant's treating and consulting doctors. The carrier, in fact, made general objection to introduction of these records, which was overruled.

Facts

On (date of injury), Ms. W, a woman in her early thirties, injured her back while lifting a five inch piece of pipe. The unvarying diagnosis throughout the medical records is back strain, initially severe. Although Ms. W indicated that she was told she might have a herniated disc, numerous tests and repeated magnetic resonance imaging (MRI) examinations have failed to find any evidence of herniation. What has been characterized as a "mild" bulge has been detected at the L4-5 level by such tests.

An overview of medical records follows:

-April 19, 1991: Dr. Q, initial medical report, states that claimant has muscle spasm of back, return to work on April 30, 1991.

-May 16, 1991: (Dr. M) records impression of herniated disc, pending MRI.

-June 18, 1991 medical report, Dr. M notes: physical therapy. No work. Return in three weeks. Diagnosis not described on report.

-(Dr. B): July 9, 1991 medical report/ musculoligamentous back strain. Claimant noted to be "objectively without distress." Physical therapy prescribed. MMI anticipated date of August 10, 1991. Returned to full time work anticipated July 9, 1991.

-Dr. B completed a Report of Medical Evaluation (TWCC-69), stating that claimant reached MMI effective August 13, 1991, with a 0% impairment rating, also that claimant had not returned with further complaints.

-August 1, 1991/Dr. A, River Oaks Imaging & Diagnostic: mild diffuse bulge at L5-S1, discogram. Normal CT scans.

-August 12, 1991 medical report: Dr. M diagnosed mild disc bulge at L5-S1, indicated that claimant should not return to work.

-August 30, 1991 letter from (Dr. C) to Dr. M thanks him for referral, indicates opinion that claimant has pain syndrome related to early spondylosis of L5-S1.

-September 16, 1991, a doctor for the carrier, (Dr. F), examined Ms. W under a medical examination order (MEO) and determined she attained maximum medical improvement with a 0% impairment as of the date of his examination.

-September 25-29, 1992: patient hospitalized for steroid injections, epidurogram

-September 30, 1991: physical therapy prescribed at request of (Dr. R) for acute spondylosis, lumbar area.

-October 22, 1991 letter from Dr. C to Dr. M: notes that epidurogram showed extensive adhesions through lower lumbar area, particularly around L5-S1; that negative MRI was performed October 11, 1991; that claimant had neck area pain but very minimal lumbar spasm; and recorded an impression that claimant had tension headaches with degenerative problems occurring in her neck and lumbar spine.

-Dr. M's October 19, 1991 response to Dr. F's MEO report noted that Dr. F should have reviewed a discogram performed 8/1/91, which was normal in spite of slight bulge found on MRI at L5-S1, which Dr. M opined was the source of claimant's pain.

-Dr. M opined that claimant could be lead down a path of pain reduction, and "return to a productive life in the near future."

-December 5, 1991 lumbar MRI reported as normal, nothing to specifically suggest scar tissue. "No soft tissue abnormalities demonstrated."

-December 9th letter from Dr. C to adjuster noted that MRI performed day before was normal; that claimant was diagnosed with urinary tract infection the week before; that claimant will remain in lumbosacral brace for 3-4 weeks more; and that claimant has been referred to chronic pain management team.

-January 22, 1992: Dr. C prescribes a walker because claimant has fallen 3-4 times a day due to weakness in legs due to back injury.

-January 30, 1992: Dr. C's letter to carrier, noted very severe muscle spasm in back, normal MRIs and CT scans except for mild diffuse bulge; noted that

claimant reported frequent falls; that her office observed one fall in office from which claimant got up and moved quite quickly, although she was in pain; explained why walker was prescribed; opined that ligaments were likely torn at time of accident, but "at the current time we have not been able to identify these." Claimant opined not to be a surgical candidate.

-February 10, 1992: Dr. F, at adjuster's request, reported on new medical information he reviewed. He stated that the fact that claimant reported falling in and of itself offered no information, as there was no demonstrable objective reason for her to fall. He noted that bladder problems could be related to steroids prescribed by Dr. C. He found no evidence of ligament tears as offered by Dr. C. He opined that functional overlay was the basic problem.

-February 19, 1992: Dr. R's medical report. Impression: "Early spondylosis with degenerative disc disease at L4-5 and L5-S1 with an exaggerated pain response." Noted that claimant continued in pain management, and receives pain medications.

-March 9, 1992: Paramedical therapeutic notes indicate favorable pain response to hypnosis.

-March 19, 1992: Dr. R notes that claimant is participating in pain clinic, has been making improvement but continues to suffer from pain. Noted also that physical therapy would resume, and psychotherapy would continue.

(Dr. P) was appointed as designated doctor in February 1992 after the carrier contacted the Commission asking for an appointment of doctor, stating that the claimant and carrier were unable to agree upon a designated doctor to resolve the dispute. Dr. P's specialty is orthopedic surgery. Dr. P's curriculum vita, in evidence from the first hearing, states that he is licensed to practice in two states. He belongs to 12 professional and specialty spine organizations. He is on the clinical faculty of Baylor College of Medicine as an assistant professor in the Department of Orthopedic Surgery. He is an instructor at UT Medical School/Houston. He is on active medical staff at two hospitals, and the courtesy staff of nine others.

A list from the Harris County civil courts, put into the record on remand, indicates that Dr. P has been a witness for both plaintiffs and defendants in personal injury and workers compensation cases. As noted in the prior Appeals Panel decision in this case, it was reported in early March 1992 that Dr. P had been the intended victim of a thwarted murder

attempt.

Dr. P examined claimant on March 30, 1992; in a 2-1/2 page report, Dr. P notes that claimant has complained of continued and intense pain. Dr. P noted that range of motion in the hips "is full, without limitation and without reproduction of symptoms". Dr. P observed a normal x-ray taken March 4, 1992. Dr. P noted that claimant would not attempt to bend forward, but that she could, "with cajoling", sustain and demonstrate normal function to hip abductors, extensors, quads, heel and toe. She would not allow hip hyperextension to be done for femoral stretch testing. Straight leg raising and Deyerle-May examination failed to elicit complaints of pain about her lower back, buttocks, or lower extremities. Dr. P noted that claimant, based upon subjective complaints, has had exhaustive treatment over nearly a year, with no significant improvement in her symptoms. He stated that "[l]acking objective abnormality, however, her symptoms and incapacity seem to be on the basis simply of her subjective complaints of incapacity." He noted that only the discogram provided any objective indication, but was not supported by the other studies, including MRI. Dr. P noted that "[t]he discogram surely at best is a secondary diagnostic procedure and even as a provocative study, at times it's (sic) can be suspect."

As noted in our prior opinion in this case, there is one place where an obvious typographical error has been made as to claimant's gender, but she is otherwise throughout the report clearly described as female. Dr. P goes on to "wrap up" by noting that her complaints are subjective, and that he finds that claimant has no significant permanent impairment or loss of function. He completed a TWCC-69 stating that claimant reached MMI on March 30, 1992, with 0% impairment.

On April 1, 1992, Dr. C noted that claimant was having a urinary tract infection and needed antibiotics. Dr. C does not state that the back injury caused this, but, rather, that insurance should pay for antibiotics because the urinary problems add to her back discomfort. This letter notes, as far as claimant's back problems that "we still have not come up with any neurological damage. She apparently has a back strain." However, on April 27, 1992, (Dr. ST), urologist, in a letter to the adjuster, claimed that claimant showed "hypertonic irritable bladder compatible with neurogenic etiology." His letter purported to be based on tests rendered prior to Dr. C's April 1st letter. He stated that claimant's bladder problems were "secondary to lumbosacral pathology."

Dr. R stated in a letter to Dr. C on April 29, 1992 that "we have been unable to make any further significant progress with [claimant] and at this time I feel she is approaching maximum medical improvement" but did not certify MMI. Nevertheless, Dr. R went on in her letter to assign an impairment rating, based upon the AMA Impairment Guides, of 19% as a result of range of motion examination, plus another 5% based on her diagnosis of spondylosis, for a total of 24%. Dr. R indicated, however, that claimant's leg lifts did not meet standards of being reproducible. Although Dr. R noted that claimant demonstrated

reducible results for upper extremities, Dr. R noted that "I am unable to explain why she would have such significant weakness in the upper extremities based upon her current diagnosis."

Dr. R also indicated that claimant should return to some sort of work at the light duty level, and contact the Texas Rehabilitation Commission (TRC) for job retraining. The claimant, when questioned about this at the remand hearing, stated that she was not aware of any recommendation by Dr. R to return to light duty, and that, in any case, Dr. R was not her treating physician.

On May 1, 1992, Dr. C wrote a letter indicating that she believed claimant was totally disabled from her injuries, which she characterized as back strain, ligament strain, and neurogenic problems.

On July 1, 1992, Dr. R again recommended referral to TRC and stated that claimant "is approaching maximum medical improvement." Dr. R noted inconsistent responses to straight leg raising tests, as well as continued upper body weakness.

Claimant testified that she had not looked for work. She indicated that she feared that she might fall if she returned to work and hurt herself worse. She stated that she did not contact TRC, as recommended by Dr. R, because the agency might not have a location near her home. Claimant argued that her treating doctor knew her condition much better than Dr. P, who she asserted examined her for five minutes.

CONTINUANCE ISSUE

We do not agree that the hearing officer abused his discretion by failing to grant claimant's motion for continuance, upon his finding that there was no good cause for a continuance. The records were presented by the carrier in response to an order from the hearing officer and were hearing officer, not carrier, exhibits. Claimant admitted that she had them at least three, and possibly four, days before the hearing. Claimant, other than stating generally that she didn't have time, was not able to explain why she did not review any of the records in the three or four days preceding the hearing. Although claimant argued that her lack of education would mean she could not understand the records, she arguably would have been able to at least compare them to records she already had to determine if there were new ones she had not seen before, or to obtain the assistance of a friend to review them.

Most of records submitted are from her own doctors. Many are duplicate copies of the same record. Several were already in evidence from the first hearing in this case. The carrier said that it had produced most of the records to claimant before the first hearing. Finally, the hearing officer stated that claimant could submit written comment on any of these

records within ten days after the hearing, or to supplement them with additional records, but there is no indication that she did so. We do not find that error resulted from the denial of a continuance.

OMBUDSMAN ISSUE

The claimant recites in her appeal an "off record" discussion she says took place. As there is nothing in the record referring to this, we must note that, within the recorded testimony, claimant referred to the ombudsman, who was present at the hearing, as her assistant. The claimant, who the record indicates was not shy in voicing her objections to matters she thought were unfair, made no complaint that she had been denied the assistance of the ombudsman at the hearing. The hearing officer indicated that another ombudsman could be made available after the hearing to assist claimant in receiving records when the first ombudsman was out on medical leave. This point of error is overruled.

CONDUCT OF HEARING OFFICER

A hearing officer is charged with the duty of developing a full record, Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. Article 8308-6.34(b) (Vernon Supp. 1993) (1989 Act), and is permitted to ask questions to do this. Rule 142.2(12). Further, it must be frankly stated that claimant sometimes departed from discussion of the issues in this hearing. The questions asked by the hearing officer served the purpose of focusing claimant's testimony on issues relating to her motion for continuance, MMI and her contentions that Dr. P was biased. We overrule this point of error.

DISABILITY

The claimant complains that no one asked questions about her disability, and argues that the carrier should still pay income benefits because she is unable to work. However, temporary income benefits can be paid only until MMI is reached, even if, after MMI, the claimant still does not work. *See* Article 8308-4.23(b). Only if the hearing officer determined that Dr. P's report (as designated doctor) was against the "great weight" of other medical evidence would claimant's inability to obtain and retain employment be a factor in obtaining additional temporary income benefits. Because claimant's permanent impairment was 0%, no income impairment benefits were due. Article 8308-4.26(c). We cannot agree that it was error for the hearing officer to decline to rule on whether the claimant had disability or order income benefits to be paid.

DR. P's ALLEGED BIAS

The evidence does not establish that Dr. P was aligned with the insurance carrier or

biased against the claimant. As noted in our previous decision, we are not persuaded that the evidence indicates that the thwarted crime, occurring nearly a month prior to claimant's exam, impaired Dr. P's examination.

The computer printout from the courthouse fails to establish that Dr. P was biased. The claimant noted that she had misplaced the list of codes used on the list. She testified that she understood "WP" to mean "Witness for Plaintiff" and "WD" to mean "Witness for Defendant". It appears that these designations appear throughout the printout in cases described as WKC, PI, and PIA. Neither WD nor WP predominates over the other. It appears that Dr. P has appeared as witness on both sides of cases. The list fails to establish a reason for disallowing the designated doctor's report.

WHETHER DR. P'S OPINION IS OVERCOME BY THE GREAT WEIGHT OF OTHER MEDICAL EVIDENCE

Article 8308-4.25 and 4.26 of the 1989 Act direct the Commission to accord a designated doctor's report presumptive weight unless the great weight of other medical evidence is to the contrary. As we pointed out in our first decision, MMI does not necessarily mean that an injured worker will be completely free from pain. It appears from a review of other medical evidence that it does not amount to a "great weight" against a finding of MMI or 0% impairment. Further, objective evidence of physical incapacity is minimal, as Dr. P noted. There is sufficient evidence to support the determination of the hearing officer to adopt the decision of the designated doctor.

Regarding the claimant's complaint that she was not able to get recent medical evidence because of the carrier's failure to pay her doctor, we would note that she stated that she had last seen her doctor a month before the hearing, which would have yielded medical evidence through November 1992. The claimant did not present medical evidence from Dr. C dated after May 1, 1992, although, according to claimant's appeal, evidence would exist from that date through October 1992. There is much medical evidence already in the record from which the hearing officer could determine whether, on March 30, 1992, the claimant had reached MMI in accordance with Dr. P's findings.

WHETHER THE HEARING OFFICER ERRED IN FAILING TO EXCLUDE DR. P'S LETTER ASSERTING HE USED THE GUIDES

We find no error in the hearing officer's refusal to exclude Dr. P's letter asserting compliance with the required AMA Guides. First of all, the lack of compliance with the Guides, as we noted in the first hearing, was not really an issue between the parties. Second, it appears that this letter was provided to the claimant with the carrier's response to claimant's first request for appeal. Third, claimant did not object at the hearing to the exhibit for failure to exchange it or ask the hearing officer to exclude it. Therefore, we reject

this point of error.

We affirm the decision of the hearing officer.

Susan M. Kelley
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Robert W. Potts
Appeals Judge